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Symptoms of War Trauma Induced Psychiatric Disorders: Southeast Asian Refugees and Vietnam Veterans[1]

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This article compares the symptomatology of Southeast Asian refugees suffering from mental health disorders with that of Vietnam veterans suffering from psychiatric disorders related to war trauma. Both of these groups share common unresolved feelings and have similar clinical manifestations resulting from the intensity of wartime atrocities. Similarities in the symptoms presented by these two groups suggest the Southeast Asian refugees may also suffer from the same type of war trauma induced psychiatric disorder as the Vietnam veterans.

Since the collapse of the Saigon government in 1975, an estimated 2.5 million veterans returned from the Vietnam war, and approximately 750,000 refugees from Southeast Asia settled in the United States. An estimated 0.5 million veterans returned in need of immediate emotional help (Egendorf, *et al.*, 1981), and an estimated 1.5 million may eventually need psychiatric help (Walker and Cavernar, 1982). Likewise, a growing number of Southeast Asian (SEA) refugees are presently suffering from severe mental health problems (Owan, 1985).

Numerous explanations have been proposed for both the large number of Vietnam veterans who were emotionally disabled by their combat experiences and the intensity of their disabilities. Many of the critical factors are unique to the veterans of the Vietnam war as compared to the veterans of other wars. Guerrilla warfare tactics were the norm in the Vietnam engagement. Battle brutality involved women and children, who were often enemy combatants. Moreover, on some occasions, the combatants experienced the extreme

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emotional distress and conflict of witnessing atrocities on both sides. The psychiatric symptoms typically presented by the Vietnam veterans were given labels such as Post-Vietnam syndrome, more commonly known as Post-Traumatic Stress Disorder (PTSD).

The difficulties inherent in adjusting to a new society are often labelled as the key factors associated with the psychiatric problems of the SEA refugees. Poverty, illiteracy, prolonged dependency on welfare, sociocultural change and isolation, language barrier, and loss of self-esteem are commonly cited as the contributing factors to their mental health problems. The wartime atrocities experienced by the vast majority of the SEA refugees, however, are rarely attributed as the primary contributing factor to their psychiatric illnesses. Vietnam veterans and the SEA refugees shared traumas from a common war and show similar symptoms of psychiatric illness.

Vietnam veterans do not have the language and cultural barriers experienced by the SEA refugees. The Vietnam veterans returned to a familiar environment, whereas the SEA refugees entered a totally foreign society. The adjustment difficulties, the language and cultural barriers, are unique to the SEA refugees. Therefore, it is not surprising that many conclude the SEA refugees suffer from psychiatric disorders that are different from the Vietnam veterans. The complexities of the SEA refugee experience of war trauma and relocation render it difficult to identify and examine all the potential determinants of their psychiatric illnesses. The focus of this study is on the similarities of the presenting symptoms of the SEA refugees who suffer from mental health problems and those Vietnam veterans suffering from PTSD.

SYMPTOM PATTERNS ASSOCIATED WITH TRAUMA-INDUCED PSYCHOLOGICAL DISORDER

Post-Traumatic Stress Disorder (PTSD): DSM-III Definition

The third edition of the Diagnostic and Statistical Manual (DSM-III; American Psychiatric Association, 1980) includes Post-Traumatic Stress Disorder (PTSD) as a sub-class within the Anxiety Disorders diagnostic category. Symptoms associated with this disorder occur after a traumatic and stressful event. Examples of such traumatic events include natural disasters (floods, earthquakes) and man-made disasters (fires, plane crashes, bombings, concentration camps). Moreover, PTSD appears to be more severe and longer lasting when the traumatic event is a deliberate man-made disaster (Silver and Iacono, 1984; Pearce, *et al.,* 1985; Lund, *et al.,* 1984). Pearce, *et al.* (1985) also reported that veterans who experienced war-related traumatic events exhibited significantly more symptoms than those who experienced non-war related traumatic events.

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PTSD as a diagnosis requires four criteria: 1) precipitation by a stressor considered severe and atypical such as rape, torture, or wartime experiences; 2) re-experiencing of the trauma through dreams and nightmares, and compulsive memories that are sometimes triggered by stimuli evocative of the events; 3) the individual experiences two or more of a group of symptoms which include irritability, memory impairment, survival guilt, startle response, and sleep disturbance; 4) development of a sense of detachment and loss of interest in current life situations. Although not considered a true dissociative state, the individual often loses a sense of emotional and sometimes physical connection to his/her present surroundings.

The DSM-III also identifies irritability, depression, anxiety, aggressive and impulsive behavior, emotional lability, and somatic representations as part of the emerging patterns of symptoms. In cases of chronic and delayed PTSD, symptoms can endure beyond the acute stage and manifest themselves after a deferment that sometimes involves a number of years.

Symptom Patterns Associated with Vietnam Veterans

The effects of war experiences on the Vietnam veterans have received considerable attention from clinicians and researchers concerned with war trauma induced psychological disorders. There have been numerous studies focusing on the reliability of DSM-III specifications on the diagnosis of PTSD and the diagnostic instruments pertaining to PTSD (Silver and Iacono, 1984; Krystal, *et al.,* 1986; Laufer, *et al.,* 1985; Penk, *et al.,* 1982). Research has been conducted to further clarify the extent to which other psychiatric syndromes routinely coexist with PTSD (Silver and Iacono, 1984; Sierles, *et al.,* 1986). The emotional reactions typically associated with the Vietnam veterans have been documented (Silver and Iacono, 1984; Stutman and Bliss, 1985; Krystal, *et al.,* 1986; Laufer, *et al.,* 1985; Glover, 1984; Penk, *et al.,* 1982). For example, clinical work with Vietnam veterans suggested that unresolved feelings which contribute to PTSD are linked with the traumatic events experienced during the war (Lund, *et al.,* 1984) and survival guilt (Glover, 1984).

Lund, *et al.* (1984) conducted a survey on 43 Vietnam veterans using the Combat Exposure Scale (an assessment tool constructed from dichotomous questions about seven stressful events). They found that the stressfulness of the trauma experienced during the war related significantly to a positive diagnosis of PTSD and the intensity of the presenting symptoms. Pearce, *et al.* (1985) compared the frequency of symptoms typical of the diagnostic criteria for PTSD among those Vietnam veterans with a) a war-related traumatic event; b) a non-war related traumatic event; or c) no traumatic event. Their results showed the two groups which experienced a traumatic event had significantly more symptoms than the group which never had such experience. Moreover, the group that experienced a war-related trauma

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had more symptoms than the group that experienced a non-war-related trama. Silver and Iacono (1984) compared symptom intensity between Vietnam veterans (N=406) and non-Vietnam veterans (N=63) who sought counseling for personal problems. The Vietnam veterans attested to experiencing significantly greater intensity of PTSD symptoms than the non-Vietnam veterans, and the authors concluded the experience and degree of atrocities strongly relate to the manifestation of PTSD symptoms. A Center for Disease Control's large scale Vietnam Experience Study (1987) also found the postservice mortality among the Vietnam veterans was 17 percent higher than other war veterans. The causes of death included motor vehicle accidents, suicide, homicide, and accidental poisoning.

The clinical characteristics of survival guilt are also found in the Vietnam veterans (Glover, 1984). This conflict clinically manifests itself through chronic depression or feelings of persecution. Other behavioral patterns include obesessive-compulsive rituals, aggression, somatic disorders, and psychotic symptoms (Niederland, 1964). Depression, aggression, and somatic disorders are all common symptoms experienced by the Vietnam veterans with the diagnosis of PTSD. Silver and Iacono (1984) suggested that depression and anger should be included in the PTSD diagnostic criteria. Other studies have examined the intensity of survival guilt associated behavior patterns in relation to PTSD (Glover, 1984; Berger, 1977) and found a positive correlation.

Our overview of research conducted since 1980 indicates a large degree of consistency in the types of symptoms presented by the Vietnam veterans suffering with psychiatric illnesses that are associated with their war experience. The constellation of Vietnam veterans' presenting symptoms include severe depression, intense anxiety and panic attacks, explosive and aggressive behaviors, recurrent battle dreams and nightmares, sleep disorders, interpersonal problems, severe startle reactions, hallucinations, and somatic symptoms. Several behaviors which have been described as inordinately common among these veterans include low frustration tolerance, mistrust, lack of goal orientation, suicidal ideation, detachment from others, helplessness, concentration difficulty, impaired memory, marital problems, and employment difficulties (Van Kampen, *et al.,* 1986). Although the diagnosis of PTSD does not completely and compactly integrate all the presenting symptoms of Vietnam veterans, this diagnosis best describes the trauma-induced psychiatric illness from which the Vietnam veterans suffer.

Symptom Pattern Associated with SEA Refugees

The prevalence and the severity of mental health problems among the SEA refugee population is not commonly appreciated by the general American public; however, those who work closely with SEA refugees are quite aware of this phenomenon.

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Studies of SEA refugee mental health problems usually focus on the issue of sociocultural maladaptation among this population. We are aware of only two published articles that connect PTSD in the SEA refugees with their symptoms (Kinzie, *et al.,* 1984; Boehnlein, *et al.,* 1985).

Analysis of SEA refugee cases referred for psychiatric treatment often reveal symptoms and behaviors which fall within the parameters of PTSD. The following two case examples illustrate the symptoms typically seen in the SEA refugees with mental health problems.

> Case #1: A 32-year-old male was trained as a soldier since elementary school and worked for the CIA during the Vietnam conflict. He witnessed the deaths of friends and relatives throughout his service:
>
> After the first six months of his resettlement in the United States, he began to experience feelings of hopelessness and depression. He began to suffer from sudden uncontrollable shaking of his limbs and from stinging pain in his muscles. His family noted that he began to withdraw from friends and community. Although exhaustive physical testing proved negative for physical disorders, he continued to believe that he was physically ill. He became increasingly preoccupied with memories of the war and of the refugee camp. He was convinced he had a disease contracted from the unsanitary conditions under which he had been forced to live.
>
> Though employed and supporting his family, he quit his job due to his "shaking". This patient also withdrew from the rest of his community and "dropped out of sight". At the writing of this article, the authors are not aware of any services provided to this patient nor the whereabouts of this patient.
>
> Case #2: A 37-year-old male witnessed the deaths of his mother, 3 siblings, and 8 cousins. He was first forced into an arranged marriage by the Khmer Rouge, then imprisoned for stealing a sweet potato. During the six months of his imprisonment he was beaten daily. Upon his release from prison, he was physically emaciated and had chronic unremitting pain thoughout his body. This pain has remained with him until this day.
>
> Within several months of resettlement in the United States, he became depressed and admitted having daily nightmares and bad dreams. The patient has not worked since his arrival in the U.S. He also experienced somatic pains and fits of rage resulting in his physically striking his wife and young children without provocation. He told an examining physician he was unaware of hitting his children because he had been having flashbacks of the war.

The symptoms manifested in these case examples, as well as in other SEA patients, are similar to the symptoms described in the Vietnam veterans

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diagnosed as suffering from PTSD. As with Vietnam veterans, severe depression, explosive and violent behaviors, somatic symptoms, recurrent nightmares, and intrusive thoughts are symptoms also commonly shown by the SEA refugees. As a result of their (both SEA refugees and Vietnam veterans) traumas, their daily lives are disrupted, as evidenced by the behavioral patterns of detachment, aggression, intrusive memories, loss of appetite, sleep disturbance, and other facets of the PTSD which inhibit interpersonal relationships and normal daily functions. The ultimate manifestations in both groups are disturbed family relationships, marital problems, and unemployment.

PSYCHIATRIC SYMPTOMS AND BEHAVIORAL PATTERNS OF VIETNAM VETERANS AND SEA REFUGEES

Table 1 summarizes the occurrences of stressful events experienced by the SEA refugees and the Vietnam veterans in Southeast Asia and in the U.S. This summary indicates that the common denominator of the two groups is the trauma encountered in Southeast Asia. Upon arrival in the U.S., the two groups' experiences begin to diverge. The events which occurred prior to arriving/returning to the U.S. may have had significant impact on the psychological well-being of the two groups.

Although the cultural response and interpretation of events might differ between SEA refugees and Vietnam veterans, the after-effects of witnessing war-time atrocities appear to be similar in these two culturally different groups of people. Similarities of the symptoms presented by these two seemingly unrelated populations suggest the SEA refugees are also suffering from the same type of war trauma induced psychiatric disorder as the Vietnam veterans. Also, a careful reading of the clinical manifestations resulting from the intensity of atrocities experienced and the survival guilt indicate both the Vietnam veterans and the SEA refugees do in fact share common unresolved feelings that contribute to their symptoms.

Past and present clinical research has debated the adequacy of DSM-III criteria for PTSD as additional symptoms were found to be prevalent among their study subjects. It may be that for those who experienced war trauma, additional symptoms need to be included in the DSM-III criteria for PTSD to enable the clinicians to diagnose reliably these patients' psychiatric disorders.

Despite DSM-III's shortcomings in the PTSD diagnosis, research results generally agree on the symptomatology of the Vietnam veterans. The diagnoses of this constellation of symptoms usually have the trauma-induced overtone. The diagnoses of SEA refugees with psychiatric problems, on the other hand, do not always fall in the category of trauma-associated disorders, even though their symptoms are similar to those of Vietnam veterans. The

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TABLE 1

OCCURRENCE OF STRESSFUL EVENTS: BY POPULATIONS, BY LOCATION

Location of Events	Potential Stressful Events Experienced By: Southeast Asian Refugees	Potential Stressful Events Experienced By: Vietnam Veterans
Southeast Asia	1. Witnessed injury or death of own parents, siblings, children or other family members due to combat.	–
	2. Witnessed injury or death of friends or fellow countrymen due to combat.	Witnessed injury or death of friends or fellow countrymen due to combat.
	3. Witnessed injury or death of U.S. servicemen.	Witnessed injury or death of U.S. servicemen.
	4. Witnessed execution of own parents, siblings, children or other family members.	–
	5. Witnessed execution of friends or other countrymen.	(For P.O.W.) Witnessed execution of own countrymen.
	6. Witnessed starvation of family, friends, or other countrymen.	(For P.O.W.) Witnessed starvation of friends or other countrymen.
	7. At constant risk of own injury or death.	At constant risk of own injury or death.
	8. Responsible for injury or death of an enemy.	Responsible for injury or death of an enemy.
	9. Responsible for injury or death of enemy civilian (include women and children).	Responsible for injury or death of enemy civilian (include women and children).
	10. At risk of being captured by enemy.	At risk of being captured by enemy.
	11. Was beaten and tortured in the "re-education camp".	(For P.O.W.) Was beaten and tortured when captured by enemy.
	12. Was in forced labor.	(For P.O.W.) Was in forced labor.
	13. Separated from family during the war or flight, safety unknown.	Separated from family which was safe.
	14. Unknown whereabouts and safety of family.	–
	15. In a familiar environment.	In a foreign environment.
U.S.	1. Not well received by American public upon resettlement.	Not well received by American public upon returning from war.
	2. Foreign environment (language, culture, urbanization, climate).	Familiar environment.
	3. Economic status: poverty.	Economic status: varied.
	4. Separated from family members whose whereabouts and status unknown.	Reunification with family.
	5. Widowed, orphaned, and death of children due to the war.	–

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aspect of sociocultural maladjustment is generally the primary focus of the research conducted on the SEA refugees.

Among the symptoms described for the Vietnam veterans and the SEA refugees, somatization, interpersonal problems, and employment difficulties are characteristics common to both populations. However, the perception of the prominence and the etiology of these behaviors are quite different when applied to one population or another.

Somatization is a channel used by SEA refugees to express their mental distress. Clinical research has confirmed the common observation that people in transition, whether cultural or geographical, are at greater risk for somatization (Coehlo and Ahmed, 1980; Lin, *et al.,* 1985a). Clinical observations comparing the SEA refugees and other Asian immigrants indicated the refugees were more likely than immigrants to somatize their psychological problems (Lin, *et al.,* 1985b). Refugee health/mental health studies have consistently highlighted this aspect of the SEA refugee symptomatology. Somatization is not unique to the SEA refugees with psychiatric disorders. These include severe types of psychosomatic manifestations such as gastric ulcers, constant body aches or headaches, anorexia, skin disorders, and insomnia. This is also a symptom found in Vietnam veterans with the diagnosis of PTSD. Severe depression is found to coexist with PTSD (Silver and Iacono, 1984) , and depression-related symptoms include somatic disorders such as sleep difficulties, decreased appetite, and sexual dysfunction. Anxiety, another symptom associated with PTSD, is also presented with somatic disorders such as tremor and dizziness.

Research on Vietnam veterans with PTSD has explored interpersonal problems as a symptom. Penk, *et al.* (1981) found that veterans who reported heavy combat involvement in Vietnam were much more likely to have interpersonal problems. Roberts, *et al.* (1982) also found that those Vietnam veterans with PTSD had significantly higher levels of difficulties in intimacy, sociability, social maladjustment, and family problems.

The issue of SEA refugees' interpersonal problems associated with PTSD, on the other hand, is rarely raised by researchers for the following reasons. First, the SEA's are stereotyped as passive and reserved. Unless one is overtly hostile or aggressive, abnormal interpersonal behaviors are usually unrecognized. Second, the language and cultural barriers between a SEA refugee patient and an American clinician makes it virtually impossible for the clinician to recognize interpersonal problems. If a SEA patient is withdrawn, it may be concluded that the patient's reticence is attributed to a lack of English facility. Third, marital and familial problems prevalent in the SEA refugee population are often dominated by the opinion that these are due to changed male-female roles and generation gap common to all other immigrant groups.

Poor employment performance is a behavior exhibited by both Vietnam veterans (Penk, *et al.,* 1981) and SEA refugees. It is interesting to note how

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different the general perceptions are about the underlying explanation for the poor employment history when they refer to Vietnam veterans as opposed to SEA refugees. Clinicians, researchers, as well as the general public would give "post-Vietnam syndrome" as the explanation for Vietnam veterans' poor employment performance. Low English proficiency and lack of transferrable job skills are usually used to explain the high unemployment rate among the SEA refugees. The prevalence of trauma-induced psychiatric disorder is not associated with SEA refugees' poor employment status in any technical papers written on the subjects of refugee resettlement or refugee employment. Somatization, interpersonal problems, and unemployment are examples which illustrate how stereotyped perceptions can generate different theories on their etiology, even though the origin may be the same.

To date, no large scale epidemiological study has been conducted on the SEA refugees to determine 1) whether or not the common psychiatric disorder suffered by this population is PTSD or other trauma-induced disorder; 2) if the prevalence of PTSD or other disorder related to trauma in this population is underestimated. The strikingly similar clinical manifestations of symptoms of the Vietnam veterans and the SEA refugees strongly suggest that a war trauma induced disorder, rather than non-trauma-related psychological distress, is a prominent and prevalent disorder found in the SEA refugee population.

CONCLUSION

Psychiatric diagnosis is extremely difficult when cultural and linguistic boundaries must be crossed. At the risk of oversimplifying that the SEA refugees suffer the same type of trauma-induced disorder as the Vietnam veterans, the hypothesis we present in this article is intended to stimulate further research on this topic. It is critical to keep in mind that although virtually all SEA refugees have experienced extremely stressful events in their becoming refugees, a generalization that all of them have severe psychiatric disorders should not be made. A distinction must be made between the psychological stress experienced by all SEA refugees and the portion of them with disabling psychiatric problems. Many SEA refugees are women and children who have lost husbands, children, and family. The deaths of family members do play a significant role in their mental health problems. Also, for those SEA refugees who were not specifically traumatized but have mental health problems, the relocation process may be one of the determinants of their problems.

Certainly language and cultural sensitivity, and aggressive out-reach efforts are crucial to the success of any mental health programs for SEA refugees. Without these built in features, any diagnostic and treatment strategies are doomed to fail. Another critical feature to the success of a

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mental health program for SEA refugees is the proper clinical and professional training and credentials of the staff involved.

Twelve years after the refugees began resettling in the U.S., this country is replete with "SEA refugee experts" who are knowledgeable about this population's cultures, needs, and, plight. These experts consist largely of English as Second Language (ESL) teachers, employment counselors, and resettlement case workers. These personnel have no clinical background nor professional training in the field of mental health. In designing mental health programs, the planners would call upon these refugee experts for their input. The expertise of clinicians trained in psychiatry, however, are rarely drawn upon. In the planning process of many mental health programs there is an overemphasis on culturally sensitive service delivery but a neglect to include clinical expertise. Indeed, the fact that to date, there is still a serious shortage of professionally trained SEA bilingual clinicians and a dearth of culturally sensitized American clinicians serving the SEAs indicates that our system in the refugee resettlement is short-sighted. To date, there are only a handful of mental health programs serving SEAs which are successful, and all of these programs consist of psychiatrists and credentialed psychiatric social workers or counselors (both American and SEA).

Another aspect which is of primary concern to the Federal Government in the area of refugee resettlement is the high welfare dependency rate among the SEA population. Millions of dollars have been spent on employment training programs and support services such as ESL, transportation, and day care to mitigate this population's employment barriers. However, the critical ingredient of helping the traumatized refugees to cope and function in the mainstream society and world of work is not there. The label of "unemployable" is too quickly pronounced on too many refugees, and these individuals are then thrusted into an isolated environment of welfare, ESL classes, and ghettos. The high prevalence of psychiatric disorders in the SEA refugee population is a non-issue in the design of most refugee employment programs. The similarly high unemployment rate in Vietnam Veteran population and the reasons for this have never been correlated for the SEA refugee population.

Mental health problems among the SEA refugee population will continue into the next few decades (Westermeyer, 1985). Given the apparent seriousness of the disorder and the amount of time that has elapsed since these SEAs became refugees, it is becoming progressively more likely that they will present themselves with multiple psychological disorders. Moreover, the longer these problems are left undiagnosed or misdiagnosed and untreated, the harder the treatment and the longer lasting these problems will be (Hendin, 1983).

It is important to bear in mind goals and objectives when designing and implementing a program. In a mental health program, professional clinical

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expertise and cultural sensitivity cannot be mutually exclusive. As Joseph Westermeyer, a renowed psychiatrist and anthropologist in the field of refugee mental health stated "lessons from each previous refugee experience tend to be lost during subsequent refugee movements, especially among those charged with implementing government policy toward refugees...It is a timeworn process, and one that has occurred in the military psychiatric services, in which the hard-won lessons of World War I were largely forgotten until they were rediscovered (at great human and economic cost) halfway through World War II. This unfortunate situation persists with regard to Indochinese refugees at the present time" (Westermeyer, 1985) . An analogy can be drawn on Westermeyer's statement. The knowledge of Vietnam veterans' and SEA refugees' traumas and psychiatric disorders is sequestered from each other. Again we are reinventing the wheel, and a knowledge base and financial resources are wasted. Meanwhile, the SEA refugees continue to suffer without much recourse.

We contend that in setting public policies, planning programs, and delivering services, those involved in refugee resettlement should be more open-minded about what other professions can offer. After all, refugee resettlement is not a profession in itself, but an integration of various technical professions applied to a population in the resettlement process. Those who have worked closely with the Vietnam veterans in various mental health programs have at least a decade's headstart in treating individuals traumatized by a war shared by the SEA refugees. Their diagnostic instruments and treatment strategies developed are likely to be more sophisticated and reliable than what is available for the SEA refugees. Thus, the SEA refugees will benefit from the transference of such knowledge.

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